SERFF Tracking Number:	*ALSB-125797106*	*State:*	*Arkansas*
Filing Company:	*Allstate Life Insurance Company*	*State Tracking Number:*	*40123*
Company Tracking Number:	*FIC258AA-1 SERIES*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*FIC258AA-1 Series*		
Project Name/Number:	*FIC258AA-1 Series/FIC258AA-1 Series*		

Filing at a Glance

Company: Allstate Life Insurance Company

Product Name: FIC258AA-1 Series	SERFF Tr Num: ALSB-125797106	State: ArkansasLH
TOI: L09I Individual Life - Flexible Premium Adjustable Life	SERFF Status: Closed	State Tr Num: 40123
Sub-TOI: L09I.001 Single Life	Co Tr Num: FIC258AA-1 SERIES	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Authors: Ronald Nissen, Karen Roberts	Disposition Date: 09/02/2008
	Date Submitted: 08/29/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: FIC258AA-1 Series	Status of Filing in Domicile: Pending
Project Number: FIC258AA-1 Series	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 09/02/2008	
State Status Changed: 09/02/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

We submit the above reference form for your attention and approval. This is a new form, not previously submitted and does not replace any currently approved form.

Description of General Use Application Form

SERFF Tracking Number:	*ALSB-125797106*	*State:*	*Arkansas*
Filing Company:	*Allstate Life Insurance Company*	*State Tracking Number:*	*40123*
Company Tracking Number:	*FIC258AA-1 SERIES*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*FIC258AA-1 Series*		
Project Name/Number:	*FIC258AA-1 Series/FIC258AA-1 Series*		

Form FIC258AA-1 is an application intended to be used with previously approved contract LU10903, approved by your state on February 28, 2008.

This form has been generated by our home office computer system. This form may also be generated using other hardware, which can result in changes in formatting (e.g., typeface, margins, page breaks), but the contents will remain unaffected.

Please note that some of the variable information on the pdfs of this form was bracketed using Adobe Acrobat. Although the bracketing appears on the attached pdf when viewed electronically, the bracketing may not appear on printed hard copies unless your printer is given special instructions to do so.

If you have any questions, please feel free to contact me at the address, phone, or e-mail provided. Thank you for your consideration of this matter.

Sincerely,

Karen M. Roberts
Senior Product & Financial Analyst
Contract Development and Filing

Company and Contact

Filing Contact Information

Ron Nissen, Product & Financial Analyst
3100 Sanders Rd., Suite M2A
Northbrook, IL 60062

rniss@allstate.com
(847) 402-3246 [Phone]
(847) 326-5224[FAX]

Filing Company Information

Allstate Life Insurance Company
3100 Sanders Road, Suite M2A
Northbrook, IL 60062
(847) 402-8112 ext. [Phone]

CoCode: 60186
Group Code: 8
Group Name:
FEIN Number: 36-2554642

State of Domicile: Illinois
Company Type:
State ID Number:

SERFF Tracking Number:	*ALSB-125797106*	*State:*	*Arkansas*
Filing Company:	*Allstate Life Insurance Company*	*State Tracking Number:*	*40123*
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Product Name:	*FIC258AA-1 Series*		
Project Name/Number:	*FIC258AA-1 Series/FIC258AA-1 Series*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	$20 per form being filed separately or retaliatory fee, whichever is greater. IL charges $50 per form.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Allstate Life Insurance Company	$50.00	08/29/2008	22213005

SERFF Tracking Number:	*ALSB-125797106*	*State:*	*Arkansas*
Filing Company:	*Allstate Life Insurance Company*	*State Tracking Number:*	*40123*
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Product Name:	*FIC258AA-1 Series*		
Project Name/Number:	*FIC258AA-1 Series/FIC258AA-1 Series*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	09/02/2008	09/02/2008

SERFF Tracking Number:	*ALSB-125797106*	*State:*	*Arkansas*
Filing Company:	*Allstate Life Insurance Company*	*State Tracking Number:*	*40123*
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Product Name:	*FIC258AA-1 Series*		
Project Name/Number:	*FIC258AA-1 Series/FIC258AA-1 Series*		

Disposition

Disposition Date: 09/02/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ALSB-125797106*	*State:*	*Arkansas*
Filing Company:	*Allstate Life Insurance Company*	*State Tracking Number:*	*40123*
Company Tracking Number:	*FIC258AA-1 SERIES*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*FIC258AA-1 Series*		
Project Name/Number:	*FIC258AA-1 Series/FIC258AA-1 Series*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Readability Certification		Yes
Supporting Document	Statement of Variability		Yes
Form	Application for Life Insurance		Yes

SERFF Tracking Number:	*ALSB-125797106*	*State:*	*Arkansas*
Filing Company:	*Allstate Life Insurance Company*	*State Tracking Number:*	*40123*
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Product Name:	*FIC258AA-1 Series*		
Project Name/Number:	*FIC258AA-1 Series/FIC258AA-1 Series*		

Form Schedule

Lead Form Number: FIC258AA-1

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FIC258AA-1	Application/ Enrollment Form	Application for Life Insurance	Initial		54	FIC258AA-1 (1108).pdf

GenBuilder℠

APPLICATION FOR LIFE INSURANCE

For Allstate Agents Use Only

Policy Number GB_____

Pre Approval Code _____

Allstate
You're in good hands.

Allstate Life Insurance Company
Standard Mail - P.O. Box 80469, Lincoln, NE 68501
Express Mail - 2940 S. 84th St. Lincoln, NE 68506-4142
Phone: 800-822-8773 FAX: 866-628-1006

For the call in process complete this application and contact home office to start the Pre-Approval Process. FIC258AA-1

A. PLAN DESCRIPTION

1. Initial Payment	2. Initial Death Benefit
$	$

B. PROPOSED INSURED - PLEASE PRINT

1. **PROPOSED INSURED NAME (First, Middle, Last)**			2. Prior name (if changed in last 2 years)	3. Occupation	
4. Street Address			5. Home Phone Number ( )	6. SSN/TIN	
7. City	8. State	9. Zip	10. State/Country of Birth	11. Sex ❑ M ❑ F	12. Date of Birth (MM/DD/YYYY)

C. OWNER/PAYOR (If other than the Proposed Insured) - *If more space is needed, use Section J*

1. **OWNER AND/OR PAYOR NAME (First, Middle, Last)** ❑ **OWNER** ❑ **PAYOR** ❑ **JOINT OWNER (For additional owners, complete section J and include items 1-10)**					
2. Street Address			3. Home Phone Number ( )	4. SSN/TIN	
5. City	6. State	7. Zip	8. Relationship to Insured	9. Sex ❑ M ❑ F	10. Date of Birth (MM/DD/YYYY)

D. OWNER TYPE

❑ Individual/Joint ❑ Non Grantor Trust ❑ Grantor Trust ❑ Other_____

Trustee Name _____ Date of Trust (MM/DD/YYYY)_____

Grantor Name (If Owner is a Grantor Trust)_____ Grantor Date of Birth (If Owner is a Grantor Trust) _____

E. BENEFICIARIES (Please complete in full)- *If more space is needed, use Section J. Percentages must add up to 100%.*

1. **BENEFICIARY 1 NAME (First, Middle, Last)**				2. Type of Beneficiary ❑ Primary ❑ Contingent	
3. Street Address			4. % Share (if not equal)	5. SSN/TIN	
6. City	7. State	8. Zip	9. Relationship to Insured	10. Sex ❑ M ❑ F	11. Date of Birth (MM/DD/YYYY)
12. **BENEFICIARY 2 NAME (First, Middle, Last)**				13. Type of Beneficiary ❑ Primary ❑ Contingent	
14. Street Address			15. % Share (if not equal)	16. SSN/TIN	
17. City	18. State	19. Zip	20. Relationship to Insured	21. Sex ❑ M ❑ F	22. Date of Birth (MM/DD/YYYY)
23. **BENEFICIARY 3 NAME (First, Middle, Last)**				24. Type of Beneficiary ❑ Primary ❑ Contingent	
25. Street Address			26. % Share (if not equal)	27. SSN/TIN	
28. City	29. State	30. Zip	31. Relationship to Insured	32. Sex ❑ M ❑ F	33. Date of Birth (MM/DD/YYYY)

F. CITIZENSHIP - *IMPORTANT - Please check "Yes" or "No" for all Parties listed*

1. Are the following U.S. citizens? (a) **Proposed Insured** ❑ Yes ❑ No (b) **Owner** ❑ Yes ❑ No (c) **Payor** ❑ Yes ❑ No (d) **Beneficiary(ies)** ❑ Yes ❑ No **If No, complete below** (If more space is needed, use Section J)

2. Name	3. Party (e.g., "Owner")	4. Country of Citizenship
5. Permanent Resident Card Number (Attach copy if available)	6. Visa Number and Type (Attach copy if available)	

G. HEALTH INFORMATION

1. Has the proposed insured:
   a. WITHIN THE LAST 2 YEARS been hospitalized or surgically treated for heart attack, chest pain, disorder of the heart, heart failure, or been confined to a nursing home or rehabilitation facility? ❑ Yes ❑ No

   b. WITHIN THE LAST 5 YEARS been diagnosed or treated for anemia or told by a member of the medical profession that they have cancer (excluding basal cell and squamous cell cancer of the skin)? ❑ Yes ❑ No

   c. EVER been diagnosed or treated by a member of the medical profession for: stroke, transient ischemic attack, mini-stroke, or other cerebrovascular disorder, diabetes treated with insulin, kidney disorder (excluding kidney stones), Alzheimer's disease or other disorder of the brain or nervous system, liver disorder, organ transplant, Acquired Immune Deficiency Syndrome (AIDS) or sought or received treatment or advice for alcohol or drug use? ❑ Yes ❑ No

2. Has the proposed insured EVER had an application for life insurance declined, postponed, rated, or cancelled? ❑ Yes ❑ No
3. Has the proposed insured:
   a. IN THE LAST 12 MONTHS experienced more than 10% unplanned or unintentional weight loss or been treated for a hip fracture? ❑ Yes ❑ No

   b. WITHIN THE LAST 6 MONTHS been unable to perform the following activities for more than 7 consecutive days without assistance: bathing, dressing, eating, toileting, transferring? ❑ Yes ❑ No

Note to Agent: If any part of questions 1, 2, or 3 is answered "Yes" or not answered, do not collect money or give receipt as coverage may not be available under this plan. If questions 1, 2, and 3 are all answered "No", please proceed to the following questions below.

4. Has the proposed insured:
   a. WITHIN THE LAST 5 YEARS had surgery or been advised to have any diagnostic test, hospitalization, or surgery that was not completed? ❑ Yes ❑ No

   b. WITHIN THE LAST 10 YEARS been diagnosed with, told by a member of the medical profession that they had, or been treated for: heart disorder, irregular heart beat, heart failure, blood pressure requiring treatment by more than two medications, vascular or circulatory disorder, fainting spells, emphysema or other chronic lung or respiratory disorder, cancer (excluding basal cell and squamous cell cancer of the skin), or diabetes? ❑ Yes ❑ No

5. Has the proposed insured used any tobacco or nicotine products IN THE PAST 24 MONTHS? ❑ Yes ❑ No
6. Provide complete details here for any questions above answered "Yes", including dates. diagnosis, treatment received for the condition and physician's name and address who treated you (If additional space is needed, use Section J):

_____

_____

_____

If questions 1, 2, 3 and 4 are all answered "No", the proposed insured may qualify for a "Standard" rate class. If questions 1, 2, and 3 are all answered "No" but any part of question 4 is answered "Yes", the proposed insured may qualify for a "Rated" rate class. A home office underwriter will review the details and determine the appropriate rate class.

H. RATE CLASS - For the call in process complete the Rate Class upon instructions from the home office underwriter

Rating Class Illustrated: ❑ Standard No Tobacco ❑ Standard Tobacco ❑ Rated No Tobacco ❑ Rated Tobacco

The Rating Class must match the illustration

I. OTHER INSURANCE/REPLACEMENT

1. Does anyone proposed for this insurance have any life insurance or annuity contracts (includes personal, business or group life):
   a. in force or application(s) pending at Allstate or any other company? (if Yes, list below) ❑ Yes ❑ No
   b. which has or will be replaced, exchanged, changed or borrowed against because of this application? (circle applicable policy numbers) ❑ Yes ❑ No

If a or b is answered "Yes," give details below and submit appropriate replacement form and policy illustrations:

Company Name	Face Amount	Policy Number	Insured/Annuitant Name
	$		
	$		

J. REMARKS/SPECIAL INSTRUCTIONS

K. PERMIT TO OBTAIN AND DISCLOSE CERTAIN DATA

1. Allstate Life Insurance Company, its reinsurers, consumer reporting agencies, and other parties acting on Allstate Life Insurance Company's behalf may get data about my health, prescription medication history, and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, and any other medical or non-medical information. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits, or for Allstate Life Insurance Company to determine its obligations under the policy issued in connection with this application.
2. Any doctor, practitioner, medical or medically related facility, Pharmacy Benefit Managers, the Veterans Administration, the Medical Information Bureau, Inc. ("MIB, Inc."), viatical settlement company, employer, consumer reporting agency, insurance company or any other person or entity which has such data about me may give such data to Allstate Life Insurance Company and its reinsurers when this permit or a copy of it is shown. All sources but the MIB, Inc., may give such data to agents or agencies that Allstate Life Insurance Company has hired to retrieve the information. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by me or otherwise required by law. Covered Entities, as defined by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether this Permit is signed.
3. Any request by Allstate Life Insurance Company for medical records is on my behalf; the information must be provided within any requirements imposed by applicable state statutes governing patient access to medical records.
4. Data about mental illness, alcoholism, sexually transmitted diseases, and the use of drugs is to be included.
5. Allstate Life Insurance Company or its reinsurers may make a brief report about me to the MIB, Inc.
6. This permit is good for 30 months after it is signed (24 months in Kentucky and Wyoming).
7. Allstate Life Insurance Company may obtain an investigative consumer report ("inspection report") on me.

   ❑ I want to be interviewed if such a report is obtained.
8. I have read this permit and know I may request a copy of it. I may revoke this authorization by writing to Allstate Life Insurance Company. I also have received the IMPORTANT INFORMATION REGARDING MEDICAL EXAMS, NOTICE REGARDING MIB, INSURANCE INFORMATION PRACTICES, NOTICE UNDER THE FAIR CREDIT REPORTING ACT and other IMPORTANT INFORMATION.

L. DECLARATIONS AND SIGNATURES

IMPORTANT INFORMATION

For applicants in Arkansas, Kentucky, Louisiana, Maine, New Mexico, Ohio and Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For applicants in Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For applicants in Florida: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

For applicants in District of Columbia, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

For Applicants in Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty for a crime and may be subject to fines and confinement in prison.

For applicants in New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

I HAVE READ THIS APPLICATION, AND I DECLARE THAT ALL ANSWERS WRITTEN ON THIS APPLICATION ARE FULL AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HAVE READ THE DISCLOSURES AND NOTICES IN SECTION M. EXCEPT IN MAINE, MISSOURI, NEW JERSEY, OREGON, AND SOUTH CAROLINA, ALLSTATE LIFE INSURANCE COMPANY IS NOT PRESUMED TO KNOW ANY INFORMATION NOT IN THIS APPLICATION. I ALSO UNDERSTAND THAT:

1. Allstate Life Insurance Company may add to or correct the application on an addendum page. Any changes are agreed to if the policy issued is accepted by me (us), but written agreement will be obtained from me for any change in insurance amount, plan, benefits, payment class or age at issue. (In West Virginia, Maryland and Pennsylvania, written consent will be obtained for any changes.)
2. Insurance will start only as provided in the Receipt and Temporary Insurance Agreement issued in connection with this application. If no receipt is issued or if insurance under it has stopped and not started again, no insurance will start by reason of the application until the policy is delivered and the premium is paid in full. No insurance will start if at that time the health of the Proposed Insured is not as described in the application.
3. I acknowledge that I have read and understand this application, including the IMPORTANT INFORMATION REGARDING MEDICAL EXAMS, NOTICE REGARDING MIB, INSURANCE INFORMATION PRACTICES, NOTICE UNDER THE FAIR CREDIT REPORTING ACT AND OTHER IMPORTANT INFORMATION. I ACKNOWLEDGE RECEIPT OF THESE NOTICES.
4. Only an officer of Allstate Life Insurance Company may change this application or waive a right or requirement. No agent may do this.
5. ALL QUESTIONS WERE ASKED OF ME AND I HAVE READ ALL INFORMATION BEFORE SIGNING.
6. I understand and agree that the statements above, along with the application, will be the basis for any insurance issued.

SUBSTITUTE FORM W-9

Under penalties of perjury, I certify that:

1. **The number on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and**
3. **I am a U.S. person (including a U.S. resident alien).**

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

SIGN HERE

Signature of Owner	Date (MM/DD/YYYY)	Signed State
Signature of Joint Owner/Trustee	Date (MM/DD/YYYY)	Signed State
Signature of Proposed Insured (if Other than Owner)	Date (MM/DD/YYYY)	Signed State

M. DISCLOSURES AND NOTICES

IMPORTANT INFORMATION REGARDING MEDICAL EXAMS

As part of the underwriting process we may ask for medical tests or exams to be completed at our expense. Common tests may include a paramedical exam, which will consist of questions about your medical history and measurements of your body including, but not limited to height, weight, blood pressure, and pulse. Blood and urine specimens are also generally collected. Undressing is not required for any of these tests.

In some instances, an EKG (Electrocardiogram) may be required. An EKG is a recording of the electrical impulses in the heart. You will be asked to lay down with your shirt unbuttoned so the EKG leads can be placed on your chest.

If you have any questions about the specific tests that will be required of you, please feel free to contact your agent.

NOTICE REGARDING THE MIB

Information regarding your insurability will be treated as confidential. Lincoln Benefit Life Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or healthy insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Lincoln Benefit Life Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INSURANCE INFORMATION PRACTICES

We will rely primarily on the information you give us. We may also get information from other sources, such as doctors, or other medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to gather information and send us an investigative consumer report as explained in the Notice Under the Federal Fair Credit Reporting Act below. You may ask to be interviewed as part of the preparation of any such report.

In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

You have the right to be told about and to see and copy items of personal information about you that appear in our files, including information contained in the investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to Underwriting Department, Allstate Life Insurance Company, P.O. Box 80469, Lincoln, Nebraska 68501.

NOTICE UNDER THE FAIR CREDIT REPORTING ACT

In compliance with the Federal Fair Credit Reporting Act, you are hereby notified that an investigative report may be made. This would be by personal interviews with neighbors, friends, associates, or other persons. This will concern the character, general reputation, personal characteristics, and mode of living (except as may be related to sexual orientation) of any person proposed for insurance. You may obtain additional information concerning the nature and scope of this investigation and a written summary of your rights under the Federal Fair Credit Reporting Act by contacting our Home Office. Our address is Allstate Life Insurance Company, P.O. Box 80469, Lincoln, Nebraska 68501. Upon your written request, you will be informed whether or not an investigation was made by us. If so, you will receive the name and address of the consumer reporting agency involved. You may receive and inspect a copy of the Investigative Consumer Report by contacting the consumer reporting agency.

N. AGENT INFORMATION AND SIGNATURE

By signing this application as the writing representative, I CERTIFY THAT, except as otherwise provided in the answer to Question 1 of Section I (Other Insurance/Replacement), the applicant does not own any existing life insurance or annuity and REPLACEMENT of existing life insurance or annuity IS NOT INVOLVED in this transaction. This also certifies that I have complied with all applicable state replacement laws and regulations in my professional judgment, and if a replacement is involved, it is in the best interest of the policyholder.

I hereby certify that to the best of my knowledge and belief the information provided in this report by the Proposed Insured in the application is complete, accurate, and correctly recorded; and there is nothing adversely affecting the insurability of the Proposed Insured other than as indicated in the application. I also certify that I gave all required forms on or before the date the application was taken.

SIGN HERE

Agent Name **(Please Print)** | Date (MM/DD/YYYY)

Agent Signature | E-mail | Phone Number

Allstate Agent Number | City/State

FL License Number (Florida Only) ❑ Option A ❑ Option B

O. RECEIPT AND TEMPORARY INSURANCE AGREEMENT (REFERRED TO AS "AGREEMENT")

IMPORTANT - DO NOT SUBMIT MONEY OR GIVE RECEIPT IF:

- questions 1, 2 or 3 in the Health Information section are answered "Yes" or not answered.
- the amount of insurance applied for exceeds $1,000,000.

All checks must be made payable to **Allstate Life Insurance Company.** Do not make checks payable to the agent and do not leave the payee blank.

$ _____ has been received as a payment for life insurance on _____ (Insured Name) applied for on this date, except as limited in the Amount of Insurance section below.

NO INSURANCE WILL TAKE EFFECT EXCEPT AS DESCRIBED BELOW

When Temporary Insurance Starts

If the payment has been accepted by us and the application for life insurance has been completed on or before the date of this Agreement, temporary insurance under the Agreement will start on the later of: (1) the date of the Agreement, or (2) the date when all required medical exams have been completed, and/or lab specimens (blood, urine, or oral fluids) provided.

When Temporary Insurance Will Stop

Temporary insurance under this Agreement will stop on the first of the dates below:

1. The date we write to the Owner that we have stopped considering the application. We have the absolute right to stop.
2. The date we advise the Owner that a medical exam or lab specimen is required. Insurance under this Agreement will start again when the last of such medical requirements is done. We have the absolute right to require such medical exams and lab specimens.
3. The date we agree to issue the coverage as applied for in the application. The insurance will then be provided by the policy.
4. The date we offer to issue insurance other than as applied for in the application. We may offer to issue insurance other than as applied for in the application on any person proposed for this insurance.

We will refund the payment made for which this Agreement was given if we stop considering the application.

Amount of Insurance

If temporary insurance under this Agreement is in effect, it will have the same benefits, provisions, and limitations and be for the same amount as the plan applied for, but we will provide no more than a combined total of $1,000,000 of temporary life insurance on any one life under this and any other Temporary Insurance Agreements.

Conditions Under Which There is No Coverage

1. No insurance coverage starts under this Agreement, and we will only pay a refund of the payment made with this application if the Proposed Insured has:
   a. WITHIN THE LAST 2 YEARS been hospitalized or surgically treated for heart attack, chest pain, disorder of the heart, heart failure, or been confined to a nursing home or rehabilitation facility.
   b. WITHIN THE LAST 5 YEARS been diagnosed or treated for anemia or told by a member of the medical profession that they have cancer (excluding basal cell and squamous cell cancer of the skin).
   c. EVER been diagnosed or treated by a member of the medical profession for: stroke, transient ischemic attack, mini-stroke, or other cerebrovascular disorder, diabetes treated with insulin, kidney disorder (excluding kidney stones), Alzheimer's disease or other disorder of the brain or nervous system, liver disorder, organ transplant, Acquired Immune Deficiency Syndrome (AIDS) or sought or received treatment or advice for alcohol or drug use.
   d. EVER had an application for life insurance declined, postponed, rated, or cancelled.
   e. IN THE PAST 12 MONTHS experienced more than 10% unplanned or unintentional weight loss or been treated for a hip fracture.
   f. WITHIN THE LAST 6 MONTHS been unable to perform the following activities for more than 7 consecutive days without assistance: bathing, dressing, eating, toileting, transferring.
2. No insurance coverage starts under this Agreement if, in the answers in the application, there is any fraud or misrepresentation material to our acceptance of the risk. If there is fraud and/or material misrepresentation, we will only pay a refund of the payment made with this application.
3. No insurance coverage starts under this Agreement if a person proposed for this insurance dies by suicide while sane or self-destruction while insane. In this event, we will only pay a refund of the payment made for that insurance.
4. No insurance coverage starts under this Agreement if no payment is received or if a check or draft given as a payment is not honored by the bank.

No one can waive or change any of the terms of this Agreement.

SIGN HERE

_____ _____

Agent Signature Date (MM/DD/YYYY)

SERFF Tracking Number:	*ALSB-125797106*	*State:*	*Arkansas*
Filing Company:	*Allstate Life Insurance Company*	*State Tracking Number:*	*40123*
Company Tracking Number:	*FIC258AA-1 SERIES*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*FIC258AA-1 Series*		
Project Name/Number:	*FIC258AA-1 Series/FIC258AA-1 Series*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ALSB-125797106*	*State:*	*Arkansas*
Filing Company:	*Allstate Life Insurance Company*	*State Tracking Number:*	*40123*
Company Tracking Number:	*FIC258AA-1 SERIES*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*FIC258AA-1 Series*		
Project Name/Number:	*FIC258AA-1 Series/FIC258AA-1 Series*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 08/29/2008

Comments:

Attachment:

AR Compliance Certification.pdf

Review Status:

Satisfied -Name: Application 08/29/2008

Comments:

See Form Schedule for application.

Review Status:

Satisfied -Name: Readability Certification 08/29/2008

Comments:

Attachment:

ALIC Readability.pdf

Review Status:

Satisfied -Name: Statement of Variability 08/29/2008

Comments:

Attachment:

ALIC app SOV.pdf

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

I hereby certify that to the best of my knowledge and belief this submission complies with Ark. Code Ann. 23-79-138, Regulation 49, and Regulation 19.

Karen E Burckhardt
Digitally signed by Karen E. Burckhardt
DN: CN = Karen E. Burckhardt, C = US, O = Allstate Insurance Co., OU = Product Management
Date: 2008.08.29 09:41:31 -05'00'

August 29, 2008
Date

Signature of Officer

Karen Burckhardt
Name

Assistant Vice President
Title and/or Business Affiliation

CERTIFICATION OF READABILITY

I, Karen Burckhardt, Assistant Vice President, hereby certify that these forms achieve a Flesch reading score as listed below:

Form Number	Flesch Score
FIC258AA-1	54

Digitally signed by Karen Burckhardt
DN: CN = Karen Burckhardt, C = US
Date: 2008.08.29 08:00:46 -05'00'

Karen Burckhardt
Assistant Vice President

Date: August 29, 2008

Statement of Variability

The purpose of this document is to identify and explain the variable items in these forms. This information is organized by page number and lists those items that are variable and the reasoning for doing so. Any changes made will be for future use only and on a non-discriminatory basis.

Application FIC258AA-1 series

- **Marketing Name, Company Logo, Company Address**
  a. The marketing name and company logo are variable so that we may revise them without refilling the form with your department.
  b. Our company address is variable so we can revise the address when and if it is changed without re-filing this form with your Department.

- **Policy Number & Approval Code**
  a. The policy number and approval code will vary as this is based on customer specific information.

- **Important Information**
  a. The information may be modified to include new information to comply with company, state or federal requirements.

- **Substitute Form W-9**
  a. This section may be modified to include new information as required by state or federal requirements.

- **Notice Regarding The MIB**
  a. The address and telephone number for the MIB's information office are variable so we can revise them when and if they are changed without re-filing this form with your Department. In addition, we request the flexibility to add or change webpage and email addresses as they become available or required by the MIB office.

- **Insurance Information Practices**
  a. Our company address and telephone number are variable so we can revise them when and if they are changed without re-filing this form with your Department. In addition, we request the flexibility to add or change webpage and email addresses as they become available or required.

- **Notice Under The Fair Credit Reporting Act**
  a. Our company address and telephone number are variable so we can revise them when and if they are changed without re-filing this form with your Department. In addition, we request the flexibility to add or change webpage and email addresses as they become available or required.